BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **VANNA ZANAGNOLO, M.D.** Holder of License No. 41181 For the Practice of Medicine In the State of Arizona.	Case No. MD-09-1543A **ORDER FOR LETTER OF REPRIMAND AND CONSENT TO SAME**

Vanna Zanagnolo, M.D. ("Respondent") elects to permanently waive any right to a hearing and appeal with respect to this Order for Letter of Reprimand; admits the jurisdiction of the Arizona Medical Board ("Board"); and consents to the entry of this Order by the Board.

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of license number 41181 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-09-1543A after receiving a complaint regarding Respondent's care and treatment of a 35 year-old female patient ("KT") alleging failure to inform surgeon of the patient's post-surgical hypotension and low hemoglobin.

4. On December 18, 2008, KT presented for elective robotic laparoscopic myomectomy to treat menorrhagia. KT's medical history included a car accident that resulted in liver and spleen injury and two ectopic pregnancies treated by linear left salpingostomy and salpingectomy. KT's history also included panic attacks, for which she was taking Toprol. On her own accord, KT took a double dose of the Toprol on the day of surgery due to her anxiety, which was not reported until KT was in the recovery room after the surgery was completed. Lab data from December 15, 2008, revealed borderline thrombocytopenia with platelets of 99,000, a hemoglobin of 11.7, a hematocrit of 37.6 and

normal coagulation studies. The surgery time was three hours in length and the total operating room time was approximately four hours. Forty-five minutes of the surgery time were used to lyse the upper abdominal and pelvic adhesions before the robotic myomectomy was performed. The estimated blood loss was noted as 125cc. The total IV fluids utilized were 1700c and KT's urine output was 100cc. The anesthesia record shows that KT's blood pressure generally ranged from 85-115 over 45-60 during the course of the surgery.

5. At admission to the recovery room, KT's blood pressure was 82/41 with a pulse of 97. Her blood pressure remained low and IV bolus of crystalloid fluids was given. The blood pressure rose to 85/44, then to about 95/45. About one hour later, KT's umbilical dressing was bloody and Respondent was paged. Respondent evaluated KT in the recovery room at 17:26. KT was awake and oriented. According to Respondent, the recovery room nurse reported that KT was ready to be transferred out of the recovery area and was doing well. The recovery room nurse also reported that KT had been talkative and was producing urine. After evaluating KT, Respondent changed the umbilical dressing. KT's abdomen was soft and, according to Respondent, there was no distension. Earlier, Respondent had entered an order for a repeat H&H to be performed at 18:30. Respondent felt KT could be transferred out of the recovery area. However, two hours later, KT was found unresponsive and pulseless. A code was called and KT was intubated. During the resuscitation, KT's hemoglobin was measured at 3.9. KT was taken emergently to the operating room where she was found to have a blood filled peritoneal cavity with diffuse surface oozing due to coagulopathy. KT received 13 units packed red blood cells, three units of platelets, four units of fresh frozen plasma, and four units of cryoprecipitate. The abdominal cavity was not closed due to marked swelling. KT was transferred to the Intensive Care Unit (ICU) where she was intubated. KT's neurologic

exam and MRI were consistent with severe anoxic brain injury. KT required a decompression ventriculostomy due to a worsened neurologic status. KT failed an apnea test, and after lengthy supportive measures she expired on January 10, 2009.

6. Board staff retained a Medical Consultant to review the case. The Medical Consultant originally found that Respondent failed to identify a patient with active intra-abdominal bleeding that led to hemorrhagic shock and cardiopulmonary arrest.

7. During the initial phase of the Board's investigation, Respondent did not respond to the Board because she had not updated her contact information and thus did not receive any communications from Board staff. Once Board staff was able to locate Respondent and provide her with a proposed Consent Agreement for Surrender of her license following SIRC's review of her case on September 2, 2010, Respondent responded to the issues in the case immediately.

8. Respondent provided a response to the SIRC report, expressing her condolences to the family and apologizing for her failure to provide the Board with her change of address. She explained that the surgical field was examined prior to closing KT, at which time there was no evidence of bleeding. She stated that KT was appropriately cared for in the PACU and that her evaluation of KT on December 18, 2008 was within the standard of care. She further stated that the decision to transfer KT to the floor was reasonable based on her history of anemia, her clinical presentation, and her evaluation.

9. The MC reviewed Respondent's response and changed his opinion regarding the case. He found that Respondent evaluated KT in the recovery room and communicated with the nursing staff and anesthesiologist prior to sending KT to the floor. He ultimately concluded that Respondent did not deviate from the standard of care.

10. The Board considered this matter at its February 9, 2011 meeting. Board members expressed concern regarding the care provided. Board members voted to return the matter for further investigation.

11. A second MC reviewed the case and observed that there was no evidence of complications during the robotic myomectomy. In the PACU, the MC noted that KT developed hypotension, was noted to have a significant drop in her H and H relative to the EBL from the surgery and showed signs of bleeding from the incision. The MC pointed out that the urine output was 100cc, not 1000cc, as indicated in the original MC's report. The MC opined that Respondent failed to recognize postoperative hemorrhage and evaluate KT further when the output was noted to be low.

12. The standard of care for a postoperative patient requires a physician to evaluate the patient, and should there be a concern for complications, further evaluation should be immediately undertaken.

13. Respondent deviated from the standard of care by failing to recognize postoperative hemorrhage, and by failing to perform further evaluation sooner.

14. Subsequently, KT suffered massive hemorrhage leading to cardiac arrest and death.

CONCLUSIONS OF LAW

1. The Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The acts described above constitute unprofessional conduct pursuant A.R.S. §32-1401(27)(q) ("[a]ny conduct that is or might be harmful or dangerous to the health of the patient or the public."); A.R.S. §32-1401(27)(s) ("[v]iolating . . .or attempting to violate, directly or indirectly, or assisting in or abetting the violation of or conspiring to violate any provision of this chapter."); A.R.S. §32-1435 ("(A)Each active licensee shall promptly and in

writing inform the Board of the licensee's current residence address, office address and telephone number and of each change in residence address, office address or telephone number that may later occur. (B) The board may assess the costs incurred by the board in locating a licensee and in addition a penalty of not to exceed one hundred dollars against a licensee who fails to comply with subsection B within thirty days from the date of change. Notwithstanding any law to the contrary, monies collected pursuant to this subsection shall be deposited in the Arizona medical board fund"); §32-1401(27)(dd) ("[f]ailing to furnish information in a timely manner to the board or the board's investigators or representatives if legally requested by the board.)

ORDER

IT IS HEREBY ORDERED THAT Respondent is issued a Letter of Reprimand.

DATED and effective this 11th day of AUGUST, 2011.

ARIZONA MEDICAL BOARD

(SEAL)

By: _____
Lisa S. Wynn
Executive Director

CONSENT TO ENTRY OF ORDER

1. Respondent has read and understands this Consent Agreement and the stipulated Findings of Fact, Conclusions of Law and Order ("Order"). Respondent acknowledges he has the right to consult with legal counsel regarding this matter.

2. Respondent acknowledges and agrees that this Order is entered into freely and voluntarily and that no promise was made or coercion used to induce such entry.

3. By consenting to this Order, Respondent voluntarily relinquishes any rights to a hearing or judicial review in state or federal court on the matters alleged, or to

challenge this Order in its entirety as issued by the Board, and waives any other cause of action related thereto or arising from said Order.

4. The Order is not effective until approved by the Board and signed by its Executive Director.

5. All admissions made by Respondent are solely for final disposition of this matter and any subsequent related administrative proceedings or civil litigation involving the Board and Respondent. Therefore, said admissions by Respondent are not intended or made for any other use, such as in the context of another state or federal government regulatory agency proceeding, civil or criminal court proceeding, in the State of Arizona or any other state or federal court.

6. Upon signing this agreement, and returning this document (or a copy thereof) to the Board's Executive Director, Respondent may not revoke the consent to the entry of the Order. Respondent may not make any modifications to the document. Any modifications to this original document are ineffective and void unless mutually approved by the parties.

7. This Order is a public record that will be publicly disseminated as a formal disciplinary action of the Board and will be reported to the National Practitioner's Data Bank and on the Board's web site as a disciplinary action.

8. If any part of the Order is later declared void or otherwise unenforceable, the remainder of the Order in its entirety shall remain in force and effect.

9. If the Board does not adopt this Order, Respondent will not assert as a defense that the Board's consideration of the Order constitutes bias, prejudice, prejudgment or other similar defense.

Vanna Zanagnolo Dated: 07/11/2011

VANNA ZANAGNOLO, M.D.

EXECUTED COPY of the foregoing mailed this 14th day of Aug, 2011 to:

Robert F. Kethcart
Snell & Wilmer L.L.P.
One Arizona Center
Phoenix, AZ 85004-2202

ORIGINAL of the foregoing filed this 14th day of Aug, 2011 with:

The Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, AZ 85258

Arizona Medical Board Staff